Scenario 1: 30 YOM - Schizophrenia Spectrum Disorder (Psychotic Break)

Scenario Set Up	Equipment: Tell the EMT's that they have a 1. Full EMT trauma/ medical kit 2. Full oxygen setup (NRB & NC) 3. Soft Restraints 4. BGL Monitor 5. Vital Signs Monitor (BP Cuff, stethoscope, pulse oximeter) 6. Flashlight (for pupils) 7. They should have a physical portable radio 8. A clipboard for documentation!! (make sure to encourage an EMT to document, if they don't sucks to suck) PROCTOR: **Proctor 1 (Patient):** Male, mid-30s, appearance is dirty and unorganized, barefoot, pacing and muttering. Increaszingly paranoid — believes "the voices are tracking him." Cooperative but volatile if startled. - Patient: You are allowed to act as you will! It's up to you how to make the schizophrenic patient seem… you can also escalate the situation into a PD assist for restraints!! (but if you do MAKE SURE the EMT's **must** call medical direction beforehand!! Otherwise it's illegal). Feel free to dramatize the patient! - Hint… sometimes remain calm and sometimes shout "STOP WATCHING ME" - Try pacing around away from the scene (not too far) but make it hard for the EMT's to collect intel on you. - If any EMT raises their voice, steps too close without permission, or contradicts your hallucinations, become agitated and shout, "You're one of them!" **Proctor 2 (Bystander):** Female, café owner who called 911. Knows the patient ("He's usually quiet but off his meds again… he hasn't been sleeping or eating"). - Seem non-chalant and overdramatize the character as someone who "knows it all" be annoying and make an annoying voice with it (hell even add bubblegum chewing to it). But return to your normal voice when proctoring information to the patients - Also! Talk fast and pretend as though you've seen the patient many times. Seems low-key rude to make the other EMT's lives harder in collecting information. - Also at any point if restraints are added to the patient say "Is he going to jail again? He doesn't need cops — he needs medicine!"

	Background (getting into character): ● The patient, **Marcus**, is a 34-year-old unhoused male known locally for talking to himself and visiting the café for water. ● For the last few days he's been shouting at cars and claiming "the city put transmitters in the streetlights." ● Today he walked into the café screaming that "the lights are watching me" and knocked over a table. ● The café owner cleared the space and called 911, screaming as though her life was in immediate danger.
Dispatch	"BMRC Unit (group #), respond to 500 Elm Street — male, mid-30s, reportedly agitated, yelling, and possibly experiencing a mental health crisis. Caller states no weapons observed but scene is chaotic. Law enforcement en route."
Scene Size Up	● Dim café interior, one overturned table and chair, bystanders outside watching through the window. ● Marcus stands in the corner near a window, sweating, mumbling to himself, "They're watching me… I can hear them through the lights." ● No visible weapons, but erratic pacing and clenched fists. ● PD officers staged outside per protocol, waiting for EMTs to assess first contact. Life Threats: ● None immediately apparent, but potential for **sudden violence** or **self-harm** if the patient panics. ● No major bleeding or trauma.
Pertinent Primary Assessment Findings	**AVPU:** Responds to voice; intermittently alert but distracted by hallucinations. **A&O ×:** 1–2 (Knows name, unsure of location or time). **Airway:** Patent, speaking in full sentences though pressured and tangential. **Breathing:** 22/min, non-labored, clear. **Circulation:** Rapid radial pulse, slightly diaphoretic, skin warm and flushed.
Pertinent Secondary Assessment	Patient: You can make the responses up, but follow the guideline of how you think the patient will sound and answer the questions **SAMPLE (according to patient)**

Findings	● **A:** No known allergies ● **M:** Mentions "some pills" he stopped taking because "they made me feel electric." (Haloperidol or risperidone likely.) ● **P:** Diagnosed schizophrenia; history of multiple 5150 holds. ● **L:** "water and half a donut yesterday." ● **E:** Has been hearing voices commanding him to "stay away from the light." **<u>OPQRST (according to patient):</u>** ● No pain reported. ● "The voices won't stop. They know where I am." **<u>AEIOU-TIPS (for EMT consideration):</u>** ● No signs of trauma, stroke, or hypoglycemia (BGL normal 98 mg/dL). ● Presentation consistent with **acute psychotic decompensation** (medication non-compliance + poor nutrition + sleep deprivation). **<u>SAMPLE (according to bystander)</u>** ● **A:** Doesn't know ● **M:** Mentions "probably some pills", … make assumptions that they take random medications "I think he takes like zoloft or something, you know my aunt took some of that and… (ramble off!!)" ● **P:** "I think he has schizophrenia… he sometimes talks to himself in the corner of the restaurant. He scares all my patrons like this isn't a halloween store… (ramble)" ● **L:** "I don't know" ● **E:** "He threw my furniture, it was scary (ramble on!!)"
Vitals	Vitals Initial After Calming / during reassessment BP 148/94 → 132/88 HR 118 bpm (regular) → 102 bpm RR 22/min → 18/min BGL 98 mg/dL → 98 mg/dL

	SpO_2 97% → 98% Room Air Temp. 99.1 ºF → 99.1 ºF

Treatments	**<u>Treatments:</u>** ● **Scene safety first:** Ensure exits are clear; PD remains staged until requested. ● **Approach slowly:** Calm tone, hands visible, avoid sudden moves. ● **Engage empathetically:** "Hey Marcus, my name's (...), I'm here to help you. I see this light's bothering you — can we step somewhere quieter to talk?" ● **Encourage cooperation** for basic assessment; avoid physical touch unless necessary. ● **Assess for injuries / medical causes** (BGL, vitals, pupils). ● **If agitation escalates:** Request PD assist in soft restraint with verbal reassurance. (MAKE SURE TO CALL MEDICAL DIRECTION IF YOU DO THIS ROUTE!!) ● **Transport:** Non-emergent to psychiatric facility once calm; high suspicion for **acute schizophrenia exacerbation** due to medication non-compliance.
Key Points	● Always **rule out medical causes** first (AEIOU-TIPS). ● **De-escalation beats restraint.** Keep environment quiet and controlled. ● **Avoid confrontation** or arguing about delusions — instead, acknowledge feelings ("I understand that's what you're seeing"). ● **Document direct quotes** ("They're watching me") — these carry diagnostic value. ● **Homelessness complicates continuity of care** — emphasize compassionate treatment and follow local protocols for vulnerable populations.
Bonus Questions	● **What are the earliest warning signs** that Marcus might escalate? ● **When should you call for law enforcement assistance** vs. when should you continue verbal de-escalation?

	● If Marcus suddenly becomes catatonic or unresponsive, what's your **next assessment step**? ○ Reassess vitals and ABC's, transport immediately. If the patient was violent before catatonia, apply soft restraints before transport, if not, don't use them. ● If Marcus was holding a knife but not threatening you, how would you modify your **scene entry plan**? ○ Prepare a plan on how to restrain the patient with the on-scene police officers, have one person ALWAYS talking the patient through what is happening during the restraining process. ○ Have the officers go in and do their thing to disarm the patient first, and the EMT's will follow behind them to restrain with the officers.

Scenario 2: 19 YOM – Panic Attack / Hyperventilation (Anxiety Disorder)

Scenario Set Up	PPE, pulse oximeter, BP cuff, O_2 equipment. PROCTOR: You are a 19-year-old male who just had a panic attack in the middle of an exam. You're hyperventilating, clutching your chest, and convinced you're dying. Speak rapidly; become calmer when reassured. <u>Proctor's notes</u>: When BMRC responders arrive, you are sitting against the wall, shaking, pale, and visibly terrified. You keep saying: - "My heart's going to explode." - "I can't breathe—please help me." If EMTs speak gently and tell you to take slow breaths, you start to regain some control. If they talk too clinically or appear dismissive, you get more agitated <u>Bystander Role</u>: Patient's classmate is standing nearby, nervous but cooperative. She tells EMTs: "He was in our chem midterm. He just got up and ran out saying he couldn't breathe. I followed him, and he was shaking and breathing super fast." If EMTs ask, she confirms no drug or alcohol use.
Dispatch	"BMRC Unit (group #), respond Code 2 to a 19-year-old male complaining of chest tightness and difficulty breathing following a midterm exam. Caller reports the patient is anxious, pale, and hyperventilating. No trauma or known medical history
Scene Size Up	Patient seated on the ground outside a classroom, surrounded by friends. No hazards. The patient appears anxious and shaking.
Pertinent Primary Assessment Findings	AVPU: Alert A&O x 4 A- Patent B- Rapid Respiration C- skin pink, warm: pulse slightly elevated

Pertinent Secondary Assessment Findings	A - *No known drug allergies* M - *None* P - *Anxiety Disorder* L - *Had an energy drink around 8:30 AM, no food today* E - *Patient was taking a midterm exam in Dwinelle Hall after several days of poor sleep, high caffeine intake, and stress. During the exam, he began to feel his heart racing and shortness of breath, thought he was having a heart attack, left the room, and collapsed outside. Classmates found him sitting against the wall breathing rapidly and crying. 911 was called* *O - Sudden onset during midterm exam; patient states symptoms began "out of nowhere" while sitting at his desk.* *P - Worsens with thinking about the episode or focusing on breathing; slightly improves when coached to slow breathing and calm down. No change with movement or position.* *Q - Describes the sensation as "tightness" or "pressure," not sharp or stabbing. Denies any crushing pain, radiation, or burning.* *R - No radiation to arm, jaw, or back. Tingling noted only in hands and around the mouth.* *S - Rates discomfort as **7/10** at its peak, now improving to **4/10** after reassurance.* *T- Symptoms started approximately **10–15 minutes** prior to EMS arrival; intensity peaked quickly and is now slowly subsiding.*
Vitals	*Initial Vitals: BP 130/80, HR 110, RR 32, SpO_2 100%, BGL 112 mg/dL* *Reassessment Vitals: BP 124/78, HR 90, RR 18, SpO_2 99%, BGL 112, Temp 98.7°F*

Treatments	- *Rule out life-threatening causes (cardiac, asthma, hypoxia).* - *Provide reassurance, encourage slow breathing and calm environment.* - *Offer O_2 only if indicated (SpO_2 <94%).* - *Educate on anxiety vs. medical emergency, recommend follow-up with PCP or counselor.* - *Coach Controlled breathing*
Key Points	- *Recognize hyperventilation syndrome as a psychiatric/behavioral emergency.* - *Maintain empathy; anxiety is real and distressing to the patient.* - *Move patient to quiet comfortable space (avoid crowd stimulation)* - *DO NOT USE PAPER BAGS (risk of Hypoxia)*

Bonus Questions	- *How can EMTs distinguish panic attacks from true respiratory distress?*
	  - *Per ALCO assessment protocol:*
	  - Panic attack → clear breath sounds, normal SpO_2, normal BGL, and symptoms that improve with reassurance and slow breathing.
	  - True respiratory distress → abnormal lung sounds (wheezing, crackles), hypoxia, cyanosis, increased work of breathing, or altered mental status
	- *What are the dangers of using a paper bag during hyperventilation?*
	  - ALCO and state EMS guidelines prohibit paper bag rebreathing due to risk of hypoxia, especially in misdiagnosed cardiac or pulmonary emergencies.
	  - Patients may appear anxious but actually be hypoxic, acidotic, or having a cardiac event, and rebreathing CO_2 worsens these conditions.

Scenario 3: 28 YOM – Suicidal Ideation (Depression, C-SSRS)

Scenario Set Up	PPE, clipboard with C-SSRS form, soft restraints (for safety if needed), glucometer, pulse oximeter, BP cuff, stethoscope. PROCTOR: You are a 28-year-old male found sitting on the edge of a bridge railing, tearful and withdrawn. Speak softly, minimal eye contact. Deny any intent to harm others, but when asked directly, say, "I don't want to live anymore." Cooperate slowly if EMTs build rapport. <u>Proctor's note</u>: If EMTs use **empathetic, calm communication**, respond slowly: "It just doesn't matter anymore... I don't want to live like this." If they act rushed or dismissive, become more defensive: "You don't get it, just leave me alone." If asked about suicidal intent, reply: "I thought about jumping... I just don't know if I can do it." - If available, have another participant play **UCPD officer** maintaining safety at a distance. - Keep the patient seated near the "bridge edge" (or safe simulation area).
Dispatch	"BMRC Unit (group #), respond Code 2 to the pedestrian bridge near Hearst Avenue for a possible suicidal subject sitting on the overpass railing."
Scene Size Up	Law enforcement is already on scene, has cleared the area for safety. Patient is calm but emotionally distressed. No weapons present.
Pertinent Primary Assessment Findings	AVPU**:** Alert, responsive to voice A&O x 4 A- Patent B- Breathing normal, nonlabored C- Skin pale, cool; radial pulse strong

Pertinent Secondary Assessment Findings	A - No known drug allergies M - Sertraline (Zoloft) 100 mg daily for depression. Missed last 2 doses P - Depression, recent job loss, prior suicide attempt (2 years ago) L - Coffee earlier today; no food today E - Patient reports having a serious argument with his partner earlier this morning. He left his apartment upset, drove to the pedestrian bridge near campus, and sat on the railing "thinking about ending things." UCPD officers located him after a passerby called 911. Patient denies current plan or intent to jump but expresses ongoing hopelessness C-SSRS (Columbia Suicide Severity Rating Scale) Screening **a. Ask about suicidal thoughts:** "Have you wished you were dead or wished you could go to sleep and not wake up?" "Have you actually had thoughts about killing yourself?" **b. If yes, ask about intent and plan:** "Have you thought about how you might do it?" "Do you intend to act on these thoughts?" "Have you ever done anything, started to do anything, or prepared to do anything to end your life?" **c. Interpret and act:** ● **No active plan or intent:** Encourage voluntary transport to mental-health evaluation (non-emergent). ● **Active plan or recent attempt:** High risk → **immediate transport**, coordinate with **law enforcement for 5150 evaluation**. ● **Document clearly** the patient's exact words and who was notified
Vitals	*Initial Vitals: BP 124/82, HR 96, RR 18, SpO_2 98%, BGL 104 mg/dL* *Reassessment Vitals: BP 122/80, HR 88, RR 16, SpO_2 99%, BGL 104, Temp 98.2°F*
Treatments	- Ensure scene safety (law enforcement standby). - Build rapport; use calm, non-threatening communication. - Perform **C-SSRS** screening to determine suicidal risk level.

	- Offer voluntary transport for psychiatric evaluation (if unwilling, coordinate with law enforcement for 5150 evaluation per ALCO protocol). - Maintain a supportive tone throughout.
Key Points	- Focus on **verbal de-escalation** and active listening. - Maintain safety without restraint unless necessary. - Document statements and C-SSRS findings clearly.

Bonus Questions	- *What are the EMT's roles and limitations regarding 5150 holds?*
	  - The EMT's role is to **ensure scene safety**, **de-escalate**, **assess using tools like the C-SSRS**, **document suicidal statements verbatim**, and **encourage voluntary transport** to an appropriate facility
	  - EMTs **may request law enforcement** to evaluate the patient for a 5150 if the patient is a danger to self, others, or gravely disabled
	  - EMTs **cannot initiate** a 5150 involuntary psychiatric hold under California law. Only authorized personnel such as peace officers, licensed clinicians, or designated county mental health professionals can do so
	
	- *How does the C-SSRS differ from a basic suicide screening question?*
	  - The **C-SSRS (Columbia Suicide Severity Rating Scale)** is a structured, validated tool that evaluates both the presence and severity of suicidal thoughts, plans, and behaviors.
	  - Unlike a single yes/no question, it guides EMTs through levels of risk - from passive ideation ("I wish I were dead") to active intent ("I plan to harm myself today") - helping inform the urgency of intervention and documentation quality.